COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, OCTOBER 6, 2000

COMMONWEALTH OF VIRGINIA

At the relation of the

STATE CORPORATION COMMISSION

CASE NO. INS000130

Ex Parte: In the matter of
Adopting Revisions to the
Rules Governing Long-Term
Care Insurance

ORDER ADOPTING REVISIONS TO RULES

WHEREAS, by order entered herein August 10, 2000, all interested persons were ordered to take notice that the Commission would consider the entry of an order subsequent to September 14, 2000, adopting revisions proposed by the Bureau of Insurance to the Commission's Rules Governing Long-term Care Insurance unless on or before September 14, 2000, any person objecting to the adoption of the proposed revisions filed a request for a hearing with the Clerk of the Commission;

WHEREAS, the August 10, 2000, Order also required all interested persons to file their comments in support of or in opposition to the proposed revisions on or before September 14, 2000;

WHEREAS, as of the date of this Order, no request for a hearing has been filed with the Clerk of the Commission;

WHEREAS, a comment was filed with the Clerk of the Commission on September 13, 2000, by AARP requesting that the Commission adopt the proposed revisions as submitted by the Bureau of Insurance;

WHEREAS, a comment was filed with the Clerk of the Commission on September 12, 2000, by GE Financial Assurance regarding the number of activities of daily living that must be taken into account when determining the benefit trigger under 14 VAC 5-200-187;

WHEREAS, the Bureau has reviewed the filed comments and has recommended that, in response to the filed comments, there be no amendments to the proposed revisions; and

THE COMMISSION, having considered the proposed revisions, the filed comments, and the Bureau's recommendation, is of the opinion that the attached proposed revisions should be adopted;

THEREFORE, IT IS ORDERED THAT:

(1) The revisions to Chapter 200 of Title 14 of the Virginia Administrative Code entitled "Rules Governing Long-Term Care Insurance," which amend the rules at 14 VAC 5-200-20 through 14 VAC 5-200-70, 14 VAC 5-200-90, 14 VAC 5-200-110, 14 VAC 5-200-120, 14 VAC 5-200-150, 14 VAC 5-200-170, and 14 VAC 5-200-200, repeal 14 VAC 5-200-180 in its entirety, and propose new rules at 14 VAC 5-200-65, 14 VAC 5-200-155, 14 VAC 5-200-175, 14 VAC 5-200-185, and 14 VAC 5-200-187, and

which are attached hereto and made a part hereof, should be, and they are hereby, ADOPTED to be effective December 1, 2000;

(2) AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to the Bureau of Insurance in care of Deputy Commissioner Gerald A. Milsky, who forthwith shall give further notice of the adoption of the revisions to the rules by mailing a copy of this Order, together with a clean copy of the revised rules, to all insurers licensed by the Commission to write long-term care insurance in the Commonwealth of Virginia; and

(3) The Bureau of Insurance shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements of paragraph (2) above.

# CHAPTER 200.

## Rules Governing Long-Term Care Insurance.

14 VAC 5-200-20. ~~Effective date and other provisions.~~ Contracts effective prior to December 1, 2000.

~~A. This chapter shall be effective on January 1, 1992.~~

~~B. No new policy form shall be approved on or after January 1, 1992 unless it complies with this chapter.~~

~~C. No policy form shall be delivered or issued for delivery in this Commonwealth on or after January 1, 1992 unless it complies with this chapter.~~ Except as otherwise specifically provided, each long-term care policy delivered or issued for delivery in this Commonwealth prior to December 1, 2000, shall be subject to this chapter as it existed at the time the policy was issued or issued for delivery.

14 VAC 5-200-30. Applicability and scope.

Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies delivered or issued for delivery in this Commonwealth, on or after ~~January 1, 1992~~ December 1, 2000, by insurers, fraternal benefit societies, health services plans, health maintenance organizations, cooperative non-profit life benefit companies or mutual assessment life, accident and sickness insurers.

14 VAC 5-200-40. Definitions.

~~For purposes of this chapter:~~ The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise:

"Applicant" means in the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits, or in the case of a group long-term care insurance policy, the proposed certificateholder.

"Certificate" means any certificate or evidence of coverage issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this Commonwealth.

"Commission" means the Virginia State Corporation Commission.

"Expected loss ratio" means the ratio of the present value of future premiums to the present value of

future benefits over the entire period of the contract.

"Group long-term care insurance" means a long-term care insurance policy which complies with ~~§ 38.2-38.2-3523~~ § 38.2-3521.1 or § 38.2-3522.1 of the Code of Virginia delivered or issued for delivery in this Commonwealth.

"Insurer" means any insurance company, health services plan, fraternal benefit society, health maintenance organization, cooperative non-profit life benefit company, or mutual assessment life, accident and sickness insurer.

"Long-term care insurance" means any insurance policy or rider primarily advertised, marketed, offered or designed to provide coverage for not less than ~~twelve~~ 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, personal care, mental health or substance abuse services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance whether issued by insurers, fraternal benefit societies, health services plans, health maintenance organizations, cooperative non-profit life benefit companies or mutual assessment life, accident and sickness insurers. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this chapter. Health maintenance organizations, cooperative non-profit life benefit companies and mutual assessment life, accident and sickness insurers shall apply to the ~~Commission~~ commission for approval to provide long-term care insurance prior to issuing this type of coverage.

"Policy" means any individual or group policy of insurance, contract, subscriber agreement, certificate, rider or endorsement delivered or issued for delivery in this Commonwealth by an insurer, fraternal benefit society, health services plan, health maintenance organization, cooperative non-profit life benefit company, or mutual assessment life, accident and sickness insurer.

14 VAC 5-200-50. Policy definitions.

No long-term care insurance policy delivered or issued for delivery in this Commonwealth shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

"Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

"Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

"Adult Day Care" means a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

"Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

"Cognitive impairment" means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

“Continence” means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

“Dressing” means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

“Eating” means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

“Hands-on assistance” means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

"Home health care services" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

"Medicaid" ~~shall be defined as~~ means the program administered in accordance with Title 32.1 of the Code of Virginia.

"Medicare" ~~shall be defined as~~ means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965" (42 USC § 1395 et seq.), or "Title 1, Part I of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act" (Public Law 89-97 79 Stat. 286 July 30, 1965), or words of similar import.

"Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

“Personal care” means the provision of hands-on services to assist an individual with activities of daily living.

"Skilled nursing care," "intermediate care," "personal care," "home health care," and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

"Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

"Transferring" means moving into or out of a bed, chair or wheelchair.

All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," "home for adults," and "home health care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

14 VAC 5-200-60. Policy practices and provisions.

A. Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of 14 VAC 5-200-70 ~~of this chapter~~.

1. No such policy issued to an individual shall contain renewal provisions other than "guaranteed renewable or noncancellable".

2. The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

3. The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no unilateral right to make any change in any provision of the insurance or in the premium rate.

B. Limitations and exclusions. No policy may be delivered or issued for delivery in this Commonwealth as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

1. Preexisting conditions or diseases, subject to § 38.2-5204 B of the Code of Virginia;

2. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease, senile dementia, organic brain disorder or other similar diagnoses;

3. Alcoholism and drug addiction;

4. Illness, treatment or medical condition arising out of:

a. War or act of war (whether declared or undeclared);

b. Participation in a felony, riot or insurrection;

c. Service in the armed forces or units auxiliary thereto;

d. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

e. Aviation (this exclusion applies only to non fare-paying passengers).

5. Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

6. This subsection B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

C. Extension of benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

D. Continuation or conversion.

1. Group long-term care insurance issued in this Commonwealth on or after ~~January 1, 1992~~

December 1, 2000, shall provide covered individuals with a basis for continuation of coverage or a basis for conversion of coverage.

2. For the purposes of this chapter "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The substantial equivalency of benefits is subject to review by the ~~Commission~~ commission, and in doing so, the ~~Commission~~ commission shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

3. For the purposes of this chapter, "a basis for conversion of coverage" means a policy provision stating that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced) for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

4. For the purposes of this chapter, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the ~~Commission~~ commission to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the insurer, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider

system arrangements, service availability, benefit levels and administrative complexity. The determination of substantial equivalency is subject to review by the ~~Commission~~ commission.

5. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

6. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the initial group policy replaced.

7. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

a. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

b. The terminating coverage is replaced, as to an individual insured, not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:

(1) Providing benefits identical to or benefits substantially equivalent to or in excess of those provided by the terminating coverage; and

(2) The premium for which is calculated in a manner consistent with the requirements of subdivision 6 of this subsection. The determination of substantial equivalency is subject to review by the ~~Commission~~ commission.

8. Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a

reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100% of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

9. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

10. Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

11. For the purposes of this chapter, a "Managed Care Plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

E. Discontinuance and replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

1. Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

2. Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

F. Premium increases.

1. The premium charged to an insured shall not increase due to either:

a. The increasing age of the insured at ages beyond age 65; or

b. The duration the insured has been covered under the policy.

2. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under 14 VAC 5-200-185 the portion of the additional coverage shall be added to and considered part of the initial annual premium.

3. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation under 14 VAC 5-200-185, the initial annual premium shall be based on the reduced benefits.

14 VAC 5-200-65. Unintentional lapse.

A. Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

1. Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

The insurer shall notify the insured in writing of the right to change this written designation, no less often than once every two years.

2. When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subdivision 1 of this subsection need not be met until 60 days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

3. Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to subdivision 1of this subsection, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

B. Reinstatement. In addition to the requirement in subsection A of this subsection, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

14 VAC 5-200-70. Required disclosure provisions.

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall

clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

B. Riders and endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations".

E. Other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in § ~~38.2-5205.A.~~ 38.2-5205 A of the Code of Virginia shall set forth a description of such limitations or conditions, including any required number of days of confinement prior to receipt of benefits, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility

for Benefits."

F. Disclosure of tax consequences. With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

G. Benefit triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

14 VAC 5-200-90. Minimum standards for home health care benefits in long-term care insurance policies.

A. A long-term care insurance policy or certificate may not, if it provides benefits for home health care services, limit or exclude benefits:

1. By requiring that the insured/claimant would need skilled care in a skilled nursing facility if home health care services were not provided;

2. By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home or community setting before home health care services are covered;

3. By limiting eligible services to services provided by registered nurses or licensed practical nurses;

4. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

5. By excluding coverage for personal care services provided by a home health aide;

6. By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

~~5.~~ 7. By requiring that the insured/claimant have an acute condition before home health care services are covered; ~~or~~

~~6~~ 8. By limiting benefits to services provided by Medicare-certified agencies or providers~~.~~; or

9. By excluding coverage for adult day care services.

B. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

14 VAC 5-200-110. Requirements for application forms and replacement coverage.

A. Application or enrollment forms shall include the following questions designed to elicit information as to whether, as of the date of the application the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group the following questions may be modified only to the extent necessary to elicit information about accident and sickness or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificateholder has been notified of the replacement.

1. Do you have another long-term care insurance policy or certificate in force (including a health services plan contract, or a health maintenance organization contract)?

2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?

a. If so, with which company?

b. If that policy lapsed, when did it lapse?

3. Are you covered by Medicaid?

4. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

B. Agents shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List polices sold in the past five years which are no longer in force.

C. Solicitations other than direct response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be phrased as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[INSURANCE COMPANY'S NAME AND ADDRESS]

SAVE THIS NOTICE!

IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by (Company Name). Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this

long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage; I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.

1. [In the event that the replacing policy does not have exclusions or limitations for preexisting conditions this language may be deleted.] Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature of Agent or Other Representative)

_____

(Typed name and Address of Agent)

The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____

(Applicant's Signature)

D. Direct Response Solicitations: Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be phrased as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF

ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

_____

Insurance Company's Name and Address

SAVE THIS NOTICE!

IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by (Company Name). Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care

coverage is a wise decision.

1. [In the event that the replacing policy does not have exclusions or limitations for preexisting conditions, this language may be deleted.] Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. (To be included only if the application is attached to the policy or certificate.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application or enrollment form attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application or enrollment form could cause an otherwise valid claim to be denied. Carefully check the application or enrollment form and write to (Company Name and Address) within 30 days if any information is not correct or complete, or if any past medical history has been left out of the application or enrollment form.

_____

(Company Name)

E. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Such notice shall be made within five working days from the

date the application is received by the insurer or the date the policy is issued, whichever is sooner.

F. An individual long-term care policy that replaces a previous long-term care policy must be at least substantially equivalent in benefits. The substantial equivalency of benefits is subject to review by the ~~Commission~~ commission. An insured may purchase and an insurer may issue an individual replacement policy that is less than substantially equivalent in benefits only under the following conditions:

1. The insured provides to the insurer to which application for the replacement policy is made written acknowledgement and documentation satisfactory to the insurer that the insured has had a change in financial or personal circumstances sufficient to justify the replacement; and

2. The insured signs a waiver form separate from, and in addition to the replacement notice by ~~subdivisions~~ subsections C and D of this section. The waiver form shall be printed in boldface type of a size not less than 12 point, one point leaded; shall be executed at the time of application for the replacement policy; and shall be signed and dated both by the applicant and by the agent, if an agent is involved in the transaction. The waiver form shall state that the insured understands that the replacement policy applied for will provide benefits that are less than those provided by the policy being replaced; and

3. One copy of the waiver form shall be retained by the applicant, and an additional copy signed by the applicant shall be submitted to the insurer, who shall retain such copy with the applicant's file, along with the acknowledgement and documentation required in subdivision 1 of this subsection. The insurer shall also retain copies of all such acknowledgements, documentation, and waivers in a separate file of long-term care policy replacements that may be examined and verified by the ~~Commission~~ commission or its authorized representatives.

14 VAC 5-200-120. Reporting requirements.

A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

B. ~~Each~~ Every insurer shall report annually by June 30 the 10% of its agents with the greatest

percentages of lapses and replacements as measured by subsection A ~~above~~ of this section.

C. Reported replacement and lapse rates do not alone constitute a violation of the insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

F. For purposes of this section, "policy" shall mean only long-term care insurance and "report" means on a statewide basis.

14 VAC 5-200-150. Loss ratio.

A. Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60% calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

1. Statistical credibility of incurred claims experience and earned premiums;
2. The period for which rates are computed to provide coverage;
3. Experienced and projected trends;
4. Concentration of experience within early policy duration;
5. Expected claim fluctuation;
6. Experience refunds, adjustments or dividends;
7. Renewability features;
8. All appropriate expense factors;

9. Interest;

10. Experimental nature of the coverage;

11. Policy reserves;

12. Mix of business by risk classification; and

13. Product features such as long elimination periods, high deductibles and high maximum limits.

Demonstrations of loss ratios shall be made in compliance with ~~Regulation No. 22~~ the Rules Governing the Filing of Rates for Individual and Certain Group Accident and Sickness Insurance Policy Forms, Chapter 130 (14 VAC 5-130-10 et seq.) of this title.

B. Subsection A of this section shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

2. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Chapter 32 (§ 38.2-3200 et seq.) of Title 38.2 of the Code of Virginia;

3. If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than 30 days after the date of approval;

4. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

a. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

b. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

c. Any exclusions, reductions and limitations on benefits of long-term care;

d. A statement that any long-term care inflation protection option required by 14 VAC 5-200-100 is not available under this policy;

e. If applicable to the policy type, the summary shall also include:

(1) A disclosure of the effects of exercising other rights under the policy;

(2) A disclosure of guarantees related to long-term care costs of insurance charges; and

(3) Current and projected maximum lifetime benefits; and

f. The provisions of the policy summary listed above may be incorporated into a basic illustration or into the life insurance policy summary;

5. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

a. Any long-term care benefits paid out during the month;

b. An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and

c. The amount of long-term care benefits existing or remaining;

6. Any policy illustration that meets the applicable requirements of 14 VAC 5-40-10 et seq.; and

7. An actuarial memorandum is filed with the Bureau of Insurance that includes:

a. A description of the basis on which the long-term care rates were determined;

b. A description of the basis for the reserves;

c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

f. The estimated average annual premium per policy and the average issue age;

g. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

14 VAC 5-200-155. Filing requirement.

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this Commonwealth pursuant to § 38.2-3522.1 of the Code of Virginia, it shall file with the commission evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this Commonwealth.

14 VAC 5-200-170. Standards for marketing.

A. Every insurer, marketing long-term care insurance coverage in this Commonwealth directly or through its agents, shall:

1. Establish marketing procedures to assure that any comparison of policies by its agents will be

fair and accurate.

2. Establish marketing procedures to assure excessive insurance is not sold or issued.

3. Display prominently by type, stamp or other appropriate means on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

5. Every insurer, marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subsection ~~A~~.

6. At solicitation, provide written notice to the prospective policyholder and certificateholder that the Virginia Insurance Counseling and Assistance Program is available at: Virginia Department for the Aging, 1600 Forest Avenue, Suite 102, Richmond, Virginia 23229, Aging Services Hotline 1-800-552-3402.

7. For long-term care health insurance policies and certificates, use the terms “noncancellable” or “level premium” only when the policy or certificate conforms with 14 VAC 5-200-60.

B. In addition to the practices prohibited in Chapter 5 (§ 38.2-500 et seq.) of Title 38.2 of the Code of Virginia the following acts and practices are prohibited:

1. Twisting. Making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied or undue

pressure to purchase or recommend the purchase of insurance.

3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

14 VAC 5-200-175. Suitability.

A. This section shall not apply to life insurance policies that accelerate benefits for long-term care.

B. Every insurer, health care service plan or other entity marketing long-term care insurance (the "issuer") shall:

1. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

2. Train its agents in the use of its suitability standards; and

3. Maintain a copy of its suitability standards and make them available for inspection upon request by the commission.

C. 1. To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

a. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

b. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

c. The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

2. The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in subdivision 1 of this subsection. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format

contained in Form A, in not less than 12-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commission for approval as required for a policy pursuant to § 38.2-316 of the Code of Virginia.

3. A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

4. The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in Form A is prohibited.

D. The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

E. Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

F. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Form B, in not less than 12-point type.

G. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Form C. If a letter similar to Form C is sent, it may be in lieu of a notice of adverse underwriting decision as set forth in § 38.2-610 of the Code of Virginia. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

H. The issuer shall report annually to the commission the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet,

the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

~~14 VAC 5-200-180. Appropriateness of recommended purchase.~~

~~In recommending the purchase or replacement of any long-term care insurance policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.~~

14 VAC 5-200-185. Nonforfeiture of benefit requirement.

A. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of § 38.2-5210 of the Code of Virginia:

1. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection E; and

2. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

C. If the offer required to be made under § 38.2-5210 of the Code of Virginia is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

D. 1. After rejection of the offer required under § 38.2-5210 of the Code of Virginia, for individual and group policies without nonforfeiture benefits issued after December 1, 2001, the insurer shall provide a contingent benefit upon lapse.

2. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

3. The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

| Issue Age | Percent Increase Over Initial Premium |
|---|---|
| 29 and under | 200% |
| 30-34 | 190% |
| 35-39 | 170% |
| 40-44 | 150% |
| 45-49 | 130% |
| 50-54 | 110% |
| 55-59 | 90% |
| 60 | 70% |
| 61 | 66% |
| 62 | 62% |
| 63 | 58% |
| 64 | 54% |
| 65 | 50% |
| 66 | 48% |
| 67 | 46% |
| 68 | 44% |
| 69 | 42% |
| 70 | 40% |
| 71 | 38% |
| 72 | 36% |
| 73 | 34% |
| 74 | 32% |
| 75 | 30% |
| 76 | 28% |
| 77 | 26% |
| 78 | 24% |
| 79 | 22% |
| 80 | 20% |
| 81 | 19% |
| 82 | 18% |
| 83 | 17% |
| 84 | 16% |
| 85 | 15% |

| | |
|---|---|
| 86 | 14% |
| 87 | 13% |
| 88 | 12% |
| 89 | 11% |
| 90 and over | 10% |

4. On or before the effective date of a substantial premium increase as defined in subdivision 3 of this subsection, the insurer shall:

a. Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

b. Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection E of this section. This option may be elected at any time during the 120-day period referenced in subdivision 3 of this subsection; and

c. Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subdivision 3 of this subsection shall be deemed to be the election of the offer to convert in subdivision b of this subdivision.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection:

1. For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least 1% per year prior to age 50, and at least 3% per year beyond age 50.

2. For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subdivision 3 of this subsection.

3. The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional

shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection F of this section.

4. a. The nonforfeiture benefit and the contingent benefit upon lapse shall begin not later than the end of the third year following the policy or certificate issue date.

b. Notwithstanding subdivision a of this subdivision, except that for a policy or certificate with a contingent benefit upon lapse or a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of: (i) the end of the tenth year following the policy or certificate issue date; or (ii) the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

5. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

F. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would payable if the policy or certificate had remained in premium paying status.

G. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

H. The requirements set forth in this section shall become effective December 1, 2001 and shall apply as follows:

1. Except as provided in subdivision 2 of this subsection, the provisions of this section apply to any long-term care policy issued in this Commonwealth on or after December 1, 2001.

2. For certificates issued on or after December 1, 2001, under a group long-term care insurance policy as defined in § 38.2-5200 of the Code of Virginia, which policy was in force December 1, 2001, the provisions of this section shall not apply.

I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of 14 VAC 5-200-150 treating the policy as a whole.

J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under subdivision D 3, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

K. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

1. The nonforfeiture provision shall be appropriately captioned;

2. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the commission for the same contract form; and

3. The nonforfeiture provision shall provide at least one of the following:

a. Reduced paid-up insurance;

b. Extended term insurance;

c. Shortened benefit period; or

d. Other similar offerings approved by the commission.

14 VAC 5-200-187. Standards for benefit triggers.

A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

B. 1. Activities of daily living shall include at least the following as defined in 14 VAC 5-200-50 and in the policy:

a. Bathing;

b. Continence;

c. Dressing;

d. Eating;

e. Toileting; and

f. Transferring;

2. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in subdivision 1 of this subsection as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in subsections A and B of this section.

D. For purposes of this section the determination of a deficiency shall not be more restrictive than:

1. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

2. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

F. Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

G. The requirements set forth in this section shall be effective December 1, 2001, and shall apply as follows:

1. Except as provided in subdivision 2 of this subsection, the provisions of this section apply to a long-term care policy issued in this Commonwealth on or after December 1, 2001.

2. For certificates issued on or after December 1, 2001, under a group long-term care insurance policy that was in force on or after December 1, 2000, the provisions of this section shall not apply.

14 VAC 5-200-200. Standard format outline of coverage.

This section of the chapter implements, interprets and makes specific, the provisions of § 38.2-5207 of the Code of Virginia in prescribing a standard format and the content of an outline of coverage.

1. The outline of coverage shall be a freestanding document, in at least 10-point type.

2. The outline of coverage shall contain no material of an advertising nature.

3. Text which is capitalized or underscored in the standard format for outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

4. The text and sequence of text of the standard format for outline of coverage is mandatory, unless otherwise specifically indicated.

5. Format for outline of coverage:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied.] If your answers are incorrect or untrue, the company

has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which the group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

a. [Provide a brief description of the right to return - "free look" provision of the policy.]

b. [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

a. [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

b. [For direct response] [insert company name] is not representing Medicare, the federal government, or any state government.

5. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage

for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

6. BENEFITS PROVIDED BY THIS POLICY.

a. [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

b. [Institutional benefits, by skill level.]

c. [Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

7. LIMITATIONS AND EXCLUSIONS.

[Describe:

a. Preexisting conditions;

b. Noneligible facilities/provider;

c. Noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

d. Exclusions/exceptions;

e. Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude,

restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.] THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

a. That the benefit level will not increase over time;

b. Any automatic benefit adjustment provisions;

c. Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

d. If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

e. And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

[(i) Describe the policy renewability provisions; (ii) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy; (iii) Describe waiver of premium provisions or state that there are no such provisions (iv) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other

policy provision which provides preconditions to the availability of policy benefits for such an insured. In the event that the policy does not cover such preexisting conditions, that information should be included here also.]

11. PREMIUM.

[1. State the total annual premium for the policy;

2. If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

12. ADDITIONAL FEATURES.

[1. Indicate if medical underwriting is used;

2. Describe other important features.]

## FORMS

Long-Term Care Personal Worksheet, Form A (eff. ~~01/01/01~~ 12/01/00)

Things You Shuld Know Before You Buy Long-Term Care Insurance~~.~~, Form B (eff. ~~01/01/01~~ 12/01/00)

Long-Term Care Insurance Suitability Letter, Form C (eff. ~~01/01/01~~ 12/01/00)

# Long-Term Care Insurance Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must **ask** you to fill out this worksheet to help you and the company decide if you should buy this policy.

## Premium

The premium for the coverage you are thinking about buying will be [$_____ per month, or $_____ per year,] [a one-time single premium of $_____.]

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums in the future.] The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The last rate increase for this policy in this state was in [year], when premiums went up by an average of _____%]. [The company has not raised its rates for this policy.]

**Drafting Note:** The issuer shall use the bracketed sentence or sentences applicable to the product offered. If a company includes a statement regarding not having raised rates, it must disclose the company's rate increases under prior policies providing essentially similar coverage. The issuer may include rate information for up to two policy forms if the issuer has not changed rates on either policy form or for prior policies providing essentially similar coverage.

[☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

**Drafting Note:** The issuer shall use the bracketed sentence unless the policy is fully paid up or is a noncancellable policy.

How will you pay each year's premium?
☐ From my Income ☐ From my Savings\Investments ☐ My Family will pay

**Income**

What is your annual income? (check one)
☐ Under $10,000 ☐ $[10-20,000] ☐ $[20-30,000] ☐ $[30-50,000] ☐ Over $50,000

**Drafting Note:** The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)
☐ No change ☐ Increase ☐ Decrease

*If you will be paying premiums from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.*

Turn the Page

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## Savings and Investments

Not counting your home, about how much are all of your assets worth (your savings and investments)? (check one)

☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same ☐ Increase ☐ Decrease

*If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.*

## Disclosure Statement

| | |
|---|---|
| ☐ The answers to the questions above describe my financial situation. | ☐ I choose not to complete this information. |

Signed: _____ _____

(Applicant) (Date)

[☐ I explained to the applicant the importance of completing this information.

Signed: _____ _____

(Agent) (Date)

Agent's Printed Name:_____ ]

[**Note:** In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____ ]

(Applicant) (Date)

**Drafting Note:** Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

*The company may contact you to verify your answers.*

**Drafting Note:** When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

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# Things You Should Know Before You Buy Long-Term Care Insurance

**Long-Term Care Insurance**

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

- [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

**Drafting Note:** For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

**Medicare**

- Medicare does **not** pay for most long-term care.

**Medicaid**

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.

- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

**Shopper's Guide**

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

**Counseling**

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

12-1-00

# Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

**Drafting Note:** Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

*Please check one box and return in the enclosed envelope.*

☐ **Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

**Drafting Note:** Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ **No.** I have decided not to buy a policy at this time.

_____ _____

APPLICANT'S SIGNATURE DATE

*Please return to [issuer] at [address] by [date].*

Form C
12/1-00